Chapter 8
Practice and Personal Empowerment

The trans-identity theory (Nagoshi and Brzuzy 2010) we have presented in this book emphasizes an all-encompassing theory of transgender and other gender and sexual identities. Many scholars have addressed these theoretical constructs over the last several decades but, for me, in order to get to the point where personal empowerment has been possible, I needed more than any one particular framework offers. I believe the research we have done supports this position and can help professionals in mental health fields to advocate and empower individuals dealing with the challenges of negotiating a fluid gender identity in a non-fluid world.

This chapter considers the implications of our theoretical explorations and our quantitative and qualitative research findings for mental health practitioners working with non-heteronormative individuals, particularly transgender/transsexual individuals. In addition to a review of the relevant theoretical and quantitative/qualitative research literature, I present narratives from our interviews of our gay/lesbian and transgender participants and my own experiences of living through the dynamic interactions of socially constructed, self-constructed, and embodied aspects of gender and sexual identity. Consistent with our trans-identity theory, one of our prescriptions for practitioners is for a greater self-reflexivity and appreciation of the narratives of lived experiences of both the non-heteronormative client and the typically heteronormative practitioner in the therapeutic relationship.

Despite the gains we have made in the perceived fluidity of gender identity in the trans/queer communities, societal stereotypes and prejudices often make social functioning and adjustment difficult for gay, lesbian, bisexual, and transgender (GLBT) youth. In 2009, the National School Climate Survey administered by the Gay, Lesbian, and Straight Education Network (GLSEN) to 7,261 middle and high school students across the United States found that approximately 9 out of 10 LGBT students reported experiencing harassment in school in the last 12 months. Almost 67 % reported feeling unsafe at school due to their sexual orientation. In looking at school climate over the last decade, the GLSEN survey found that rates of more severe forms of harassment and bullying have not decreased (GLSEN 2012).

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Brown, Clarke, Gortmaker, and Robinson-Keilig (2004) note that "reviews of published campus climate studies for GLBT students universally indicate that these students experience discrimination, harassment, and fear and that the campus climate for them is chilly at best" (p. 9). Their survey of GLBT and non-GLBT college students on one campus found that GLBT students did perceive the campus climate more negatively and had more awareness of and participation in GLBT topics and activities. Brown et al. (2004) also found important differences between first/second year classman and upper classman in terms of the development of their ideas and feelings about GLBT issues.

Interestingly, Mustanski, Garofalo, and Emerson's (2010) study of representative samples of LGBT and non-LGBT youth found that, while LGBT youth had higher prevalences of mental disorders than a national sample of youth as a whole, prevalences of mental disorders of LGBT youth did not differ from prevalences for urban, racial/ethnic minority youth. In a later paper, Liu and Mustanski (2012) reported that self-harm in LGBT youth was correlated not only with personality risk factors, but also with prospective hopelessness and victimization associated with one's LGBT status. Taken together, these studies suggest the pervasive effects of marginalization and discrimination in increasing the risk for psychological maladjustment in any marginalized group, a theme that will continuously emerge throughout this chapter.

At the time of this authorship, transgender populations continue to exhibit some of the most significant social functioning disparities, when compared to any other demographic. A brief review of current statistics includes:

- 34 % of the MTF and 18 % of the FTM populations reported injection drug use (Simon et al. 2000).
- In a study based on large urban cities as much as 47 % of the MTF have been diagnosed with HIV (Xavier et al. 2005; Clements-Nolle et al. 2001; Simon et al. 2000; Nemoto et al. 2004).
- 80 % of MTF transgenders reported having performed sex work and 85 % had participated in unprotected anal sex (San Francisco Department of Public Health, 1999).
- According to a study by Kenegy (Xavier et al. 2005),
  - As much as 53.8 % of transgenders have been forced to have sex against their will.
  - 56.3 % of transgenders have experienced violence in their home.
  - 51.3 % have been physically abused.
- Murder rates against transgender individuals are as much as six times higher than the national average, which is more than three times higher than that of African American males, the next highest demographic (Kolakowski 1999).
- As much as 64 % of the transgender population has thought about attempting suicide and 32 % has attempted (Clements-Nolle et al. 2001).
- Even within the transgender populations, hate crimes and discrimination is further reinforced by race and ethnic intersections. According to the National Coalition for Anti-Violence Programs (2012):

- People who identified as both transgender and people of color were almost 2.5 times more likely to experience discrimination than non-transgender white individuals.
- Transgender people represented a higher proportion of hate violence survivors with injuries: transgender survivors experienced higher rates of serious injuries (11.8 %), as compared to non-transgender men (6.2 %) or non-transgender women (1.3 %).

For a fairly comprehensive overview of transgender disparities please review the Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health (Makadon et al. 2008).

Essentialist Versus Socially Constructed Gender Identity Disorder

The essentialist view of gender is that the relationships among gender, gender identity, gender roles, and sexuality, including the dominant status of men over women in societies, are natural and inevitable. To the contrary, several studies have found that only a small percentage of men and women fall exclusively in one gender role category, but rather manifest a combination of both masculinity and femininity (Devor 1989). While, as is discussed below, women working from a feminist theory perspective may challenge the gender role aspects of the essentialist view of gender, a more fundamental challenge comes from individuals who define themselves as being intersexed. Deviating from this natural gender identity classifies such individuals as being either a "joke" or as having a type of pathology (Garfinkel 1967).

Unfortunately, in order to "correct" for this "gender mishap," the individual will most likely be assigned a biological sex at birth based on their secondary sexual characteristics. This is done to help detour "pathological problems" supposedly caused by one's physical identity not matching their expected gender role. This "gender correction" was historically also the basis for once classifying homosexuality in the Diagnostic and Statistics Manual (DSM) of the American Psychiatric Association (APA) as a mental disorder, and one could argue is still the basis of the gender dysphoria diagnosis currently in the DSM (Ault and Brzuzy 2009).

Butler (1990) discusses the medical system that pathologizes transsexuality and points out the implications of such an ideology: "It assumes the language of correction, adaptation, and normalization and that something has gone awry and needs to be fixed" (p. 77). Providing a brief history of Gender Identity Dysphoria, Butler argues that GID perpetuates APA's homophobia, even though APA discarded the diagnosis of homosexuality as a disorder. Butler argues against the assumption of gender as a fixed permanent phenomenon, which is a requirement for sex reassignment surgery, and against the assumption of a dyadic structure of

gender because "the complementarity does not acknowledge the layers of gender identity and sexual orientation" (p. 78). This diagnosis not only stems from homophobia and transphobia (Nagoshi et al. 2008), but our society's overall fixation with living within the heteronormative ideal and categorization. I also think that the diagnosis is a way to take away the power of the transsexual individual by treating them as having a pathology and thus as not being functional, productive humans in our society.

Transsexualism was added as a disorder to the DSM in 1988 and was listed as Gender Dysphoria, characterized by a strong and persistent cross-gender identification, persistent discomfort with one's sex, and associated significant distress or impairment in social, occupational, or other important areas of functioning (Hird 2002). In 1994, the American Psychiatric Association's DSM-IV changed the name Gender Dysphoria Disorder to Gender Identity Disorder. The criteria for Gender Identity Disorder include: (A) A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). (B) Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. (C) The disturbance is not concurrent with physical intersex condition. (D) The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association 1994).

As Hird (2002) asserts, more ironically, the same kinds of causal factors that used to be attributed to the "disorder of homosexuality," unconscious rearing of the child in the opposite sex, too much influence of the mother/too little of the father, parental deviations from accepted masculinity/femininity, birth order, divorce, temporal lobe disorder, introversion, depression, non-adjustment to work, early stages of transvestism, narcissism, profound dependency conflicts, immaturity, and other personality disorders, continue to be regarded as causal factors for the "disorder of transsexualism." And some researchers have suggested that homosexuality is also a causal factor for transsexualism (Hird 2002).

While it can be argued that few modern clinicians believe in these causal factors for transsexualism, nevertheless, as noted above, transsexualism and transgenderism are still regarded as disorders in the American Psychiatric Association's Diagnostic and Statistics Manual DSM-IV (APA, 1994). Hird (2002) makes the case that, as with homosexuality, the distress, anger, and depression evidenced in transsexual individuals is the result of societal discrimination and not the transsexual condition itself, which appears to be an essential and unchangeable aspect of an individual's identity. The importance of not separating gender and sexual orientation in studies of lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals was also highlighted by Jagose and Kulick (2004).

Sex reassignment surgery (SRS) as a "cure" for Gender Identity disorder is controversial in raising broader issues about socially ascribed male and female gender identities and invoking strong reactions with regard to what is "best" for the person considering this type of surgery. While some transsexuals want to live as the "opposite gender," others care less about fitting into one of the two normative gender categories, "male" or "female." Some transsexuals may want to have

the surgery done, but cannot, due to costs, medical barriers, or religious reasons. Some people identify as transgender rather than as transsexual as a way to invoke a different gender identity altogether, one that does not fall into either male or female category. Many transgender individuals have little or no intention of having genital surgery (Bornstein 1994), although transgender views on SRS vary greatly depending upon personal self-definition and beliefs.

Though many may want access to the hormones and surgery, there are many obstacles to this process. There are very few surgeons willing to perform SRS. Certain steps must be followed before SRS is permitted (Harry Benjamin International Gender Dysphoria Association, 2007). Most jurisdictions and medical boards require a minimum duration of psychological evaluation, hormone replacement therapy (HRT), and living full time as a member of the "target gender," i.e., the real life experience (RLE) or real life test (RLT).

Opponents of SRS argue that getting SRS and HRT is not in the best interest of the individual. These surgeries can cost tens of thousand of dollars, and insurance companies will usually not pay for these expenses. There are also many risks associated with the surgery. Though medicine has advanced, many people are left permanently scarred and/or without physical sensation, and there are people who still die due to complications (Stryker and Whittle 2006).

Many transgender and transsexual individuals are searching for a physical embodiment that conforms to their personal sense of self. Many transsexuals are not comfortable identifying as simply "male" or "female" before or after the surgery, and neither are they aspiring to meet the stereotypical ideals of being a male or female in their postoperative life. Yet having sex reassignment surgery helps facilitate being perceived by others as a man or woman, thereby allowing individuals to better fit into society (Green 2004). In general, society requires people to fit into the male or female gender box throughout one's daily functioning, including one's driver's license, work histories, birth certificates, school transcripts, parents' wills, and what public restroom to use (Green 2004). As was expressed by several of our transgender participants in Chaps. 6 and 7, the difficulty of needing to conform to society's binary gender arrangements often becomes a secondary motivation for transsexuals to have the surgery.

Scholars and activists debate what rights transsexuals and transgenders should have regarding SRS. Leslie Feinberg (1996) argues that it is the right of the individual to be able to modify one's body through surgery. Feinberg points out that women already get HRT for menopause and fertility assistance, and many have cosmetic surgery done, such as breast implants, breast reductions, face lifts, or belly tucks. In contrast to cosmetic surgery, SRS patients must be diagnosed as having Gender Identity Disorder and must undergo extensive evaluations. To get around these institutional barriers, some transsexuals buy hormones on the street, get prescriptions from underground doctors, or travel to other countries for the surgery, placing them at further health risks (Feinberg 1996).

Feminism, queer theory, essentialism, and social constructivism, viewed comprehensively, have a transformative power. Taken together, I can, for the better, describe and ultimately empower myself to embrace my lived experience and

self-construction of my identities—trans, queer, white, female bodied, middle class (to name a few). Psychological adjustment problems are not problems with my gender identity; rather, they are my problems with being pressured to conform to socially constructed aspects of gender and sexual identities (among others) that I do not fit into "properly." Tre Wentling, in "Am I Obsessed: Gender Identity Disorder, Stress and Obsession" (2009), provides an excellent examination of how the social construction of gender identity disorder creates pathology and causes real psychological and physical suffering in our community.

The psychopathologizing of non-normative gender identity is the problem and the real mental health issue that needs community attention. The social construction of gender non-conformity as pathology greatly impacts my ability to be a healthy citizen of the world. McPhail (2004) sees the field of social work (I am a social work academic, too) as being caught between the social constructivist impulses of theoretically oriented academic researchers, who may regard all identity categories as open to interpretation, and the essentialist impulses of practitioners and political activists/advocates, who regard fixed identity categories as sources of oppression and empowerment. Her suggested solution is for social workers to "compromise" (and I would add all mental health professionals) by recognizing the tension between the essentialist, binary, oppression model of identity, and the social constructivist queer theory models. Burdge (2007), in turn, argues that social workers, deriving their theoretical bases for working with transgender individuals from queer theory and social constructivism, should "challenge the rigid gender binary, either by eliminating it or expanding it to include more gender possibilities" (p. 247). However, Burdge does not acknowledge the problem of social constructivist approaches undermining the meaningfulness of identity.

There are key differences in applying transgender theory, as opposed to feminist and queer theories, to practice. The recognition of the importance of the physical-embodiment of intersecting identities, as well as the understanding of how the narratives of lived experiences integrate the socially constructed, embodied, and self-constructed aspects of identity, are essential. Transgender theory emphasizes the understanding of how "transgressing" narratives of lived experiences integrate and empower those with oppressed intersectional identities.

In conclusion, personal empowerment of the transgender community must include and be supported by considering embodied and self-constructed identities. In addition to sharing and cultivating transcendent stories, in which the narratives of our lived experiences become an assertion of personal responsibility and transformation, at the same time, we must continue our work to eradicate the diseasing of gender identity.

I have thought a lot about how to write this chapter, and I decided to use some of my lived experiences to illuminate my own journey toward health and personal empowerment as a self-defined queer/trannies. Along with my stories, I will use excerpts from the interviews with self-defined transgender individuals done for this research project (and discussed throughout the book) that most reflect the topics I am emphasizing. Throughout, I will address some of the literature and give

examples of how professionals in community mental health fields can support the gender variant community.

I hope to highlight the importance of personal empowerment in a gender discriminating world and the elements of trans-identity theory that make this discussion possible for me. I will begin with some of my musings from 2005/2006 that drove my interest in this project. Obviously, our ideas have evolved from when we first embarked on this research together but I documented my messy thought process and what I was pondering about the topics then. I believe it is worth beginning with this moment in time. As you will note, it is really a series of questions:

> **SB Journal Entry:** (Sometime in 2005/2006) Are we condemning people who are gay for their sexual identity or for their refusal to follow gender binary-categories? Is the linking of these two the issue? If so, why do folks who are gay and those who are trans have trouble talking to each other? Is it that gay people are defying specific roles that are most threatening to straight people? And, trans-people are defying specific roles that are most threatening to gay people? Does this hierarchy of oppression make sense, since each furthers the breaking apart of prescribed sexual and gender identities even further, and is that not the ultimate threat to the stability of gender as an oppressive system.? Is not true gender liberation a complete collapse of a gender system? Is not feminism asking for the same thing? Are the trans-movement and the feminist movement more alike than the trans-movement and the gay movement?

De-Gendering

Why do/did these questions matter? At the time, these questions were a part of my own journey to personal understanding and ultimately empowerment. I needed to know more to describe my reality. In 2005/2006, I was still struggling with understanding and integrating my trans-identity and developing my personal narrative of how I got here. These questions were important jumping off points.

I am reminded of Judith Lorber's (2009) essay "A World Without Gender: Making the Revolution." She discusses how feminism abandoned the project of creating a de-gendered world and asks the important question, what would a gender equal world look like? I was and am still acutely interested in de-gendering the world. Life with gendered differences in my mind is a "separate but equal" status of second-class citizenship. In today's gender struggles, why are we trying to obtain a separate but equal status? It does not work. The dominant groups win, and the non-dominant groups lose. We have enough public policy evidence to suggest this is a flawed strategy. It has not worked for past equal rights struggles, and it cannot work for gender equality struggles today. I often think this is why our rights movement has stalled over the last couple of decades.

Why the de-gender project is so important to my own individual empowerment process brings me to the work of Judith Butler (1990) and the pathologizing of gender identity. Butler discusses the medical system that pathologizes transsexuality and points out the implications of such a stance: "It assumes the language of correction, adaptation, and normalization and that something has gone

awry and needs to be fixed" (p. 77). Providing a brief history of Gender Identity Disorder and Dysphoria (GID), Butler argues that GID perpetuates the APA's homophobia, even though the APA discarded the diagnosis of homosexuality as a disorder in the early 1970s. The World Health Organization's International Statistical Classification of Diseases and Related Health Problems (2007) classifies gender identity variance in a similar fashion as the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR, 2000), published by the American Psychiatric Association and currently under its first major revision since 1994. The revisions are critical for furthering our right to not be pathologized and because the revisions will impact the WHO definitions that have far-reaching global implications.

Some activists and scholars have called for the complete elimination of GID from the DSM (Ault and Brzuzy 2009; Burdge 2007) while others have called for modifications to the classification that puts more emphasis on the suffering individuals face from being gender non-conformists. GID assumes gender is a fixed and permanent phenomenon and thus a requirement for sex reassignment surgery, when bodies do not line up with gender identities. In this scenario, there is no way to see the fluidness of gender identity and/or sexual identity. The binary structure of gender must be maintained for the gendered system to continue uninterrupted. While activists continue to challenge the diseasing of gender identity, sex reassignment and hormone therapies will likely stay the purview of the health and mental health care systems for quite sometime. It is important for mental health professionals to know the impact of obtaining a mental health diagnosis for the purposes of body modification. The GID diagnosis takes power away from the trans community by pathologizing our lives as opposed to our being viewed as "normal"—functional and productive citizens of the world.

The depathologizing of gender variant identities, however, does not remove the problem of transgender individuals having to deal with the pervasive and pernicious transphobia that exists in society. Mental health professionals need to make clear to clients that their discomfort with their gender identity is not a pathology, but instead is an issue of having to conform to society's gender binary-norms. Mental health professionals should not recommend sex reassignment surgery just so clients can better cope with social pressures regarding gender, but instead should create a safe space for clients to create their own gender identity narratives, regardless of whether the client wants body modification procedures.

> **Transgender Interview:** It is a bit of a relief, in the sense that, there is a lot of less worry of being found out. I guess the hypothetical is that you are in a car accident and your clothes are torn, and the paramedics show up and they are like, "She's a girl. Wait, wait, what's this?" So that identity is better for everyone else on the outside. But myself? It really made no difference, whether I had surgery or not. The surgery completed me, a complete transformation, and since my personality type said, "Let's finish the job," that made the most sense. But part of the reason I had the surgery was not only for me, but was for society, just to make society feel more at ease. Which is about as fucked-up as it gets. But it is a truism, and there is not much you can do to work around that. Now, please do not misunderstand me, I had the surgery for me. But do not get me wrong by saying, there was also an ulterior motive by saying that because I had surgery, and because I now fit

into society's "norms" of gender, my life will be a little easier because of that, once I kind of get past the transition phase, and my male life is left in the past.

The categorization is not only limiting but silences the stories of the many lived experiences of individuals who cross-gender expectations. For example, in Taylor and Rupp's (2005) study, one individual describes herself as a "white gay man trapped in a black woman's body" and "omnisexual," since she is attracted to men and women of all sexual identities (p. 2118). She/he states "I am what I am." Taylor & Rupp argue that drag queens "play with and deconstruct gender and sexual categories in their performance and this makes gender and sexual fluidity and oppression visible." This "play" pushes up against the boundaries and acceptable norms of a gendered system. Ultimately, we are pressured to accept the unacceptable and any digression from normative gender expectations can create social, economic, and physical suffering.

Transgender Interview: Again, I do not see gender, I see people. Just because some have genitalia that is penises, and some vaginas, it is irrelevant to me, they are people. They are spirits. As according to Kate [Bornstein], I would probably have to say "other," because I do not need to fall into either group, although I fall more visually into the female side, again I still have a lot of traits that some people would consider very masculine. I enjoy playing sports, and when I play sports, I play to win. There is no second-best, there is no best try, I play to win. And I am cutthroat. I will do anything that is required to ruin the rules of the game. So I would probably have to say "other." "Other," with an asterisk to say that I do consider myself feminine and female, but a very aggressive female. Someone who would normally be called "bitch," because they would not play by men's rules of what women should be.

Transgender Interview: No, gender is very fluid. Two examples would be the absolute "bull-dyke" and the effeminate gay male. One is female acting with almost all traits that are male. The other is male acting with almost all traits that are female. So gender is not binary. Our society likes binaries, because it is easy and because it is quaint, and it only requires two checkboxes. However, reality and nature are no where near what society says it is, and society needs to understand that. Unfortunately, at this time in our evolutionary process that is not an issue, it is not on the board.

Transgender Interview: On the body…matching: For me, I feel like it is important that I look at every step of how to become more comfortable with myself, whatever that might be. I am thinking about top surgery, but I have pretty much ruled out taking hormones. I think that a lot of people either feel like they have to fully transition, whatever that means for them. In the f-to-m community, that means at least taking hormones and top surgery, bottom surgery not as much. I think, for me, I do not really identify as male or female, though my body does for the most part match my gender identity, so I do not really have to do anything. But for people who are in that binary system and they identify as "male" or "female" or "on their way," then I feel yes, there is a strong need for those people. If that is kind of where their model is and where their feeling is of gender, then I think it is really important, because it is really distracting to think you are one way and be perceived as another.

Transgender Interview: I think it is probably, from my personal standpoint, it is better just to be read within the binary system. …So I frequently talk about the dichotomy between trans-men and trans women, and that it is very difficult for trans-women to pass, because of size and body hair and mannerisms. Undoing the masculine socialization is very difficult. And the testosterone is in your system for such a very long time that, typically, it is very difficult to pass as a woman. But a man can look like anything. So a transman can be anything. The down-side to that is that trans-women suffer a lot of violence

> and hate crimes and things like that, because they are obviously, freakishly, not fitting into a category for a pretty extended period of time. Trans men suffer because they are completely invisible. And so, it is just…they are claiming masculine privileges that should have been there all along, and they blend in as men. By virtue of being invisible, there is not a lot of research, not a lot of studies, there is not a lot of voices, there is very little community development, things like that. It is very lonely, being a trans-man.

Part of my personal empowerment project is to continue to work for the de-gendering of society. It is a long and slow process but it should not be abandoned for smaller gains. I believe the trans community has an important role to play in the de-gendering project as our being men, women, both, and neither gives proof to the ability to live in an embodied, self-constructed, and self-defined identity.

Stories: A Path to Empowerment

Stories matter. Finding a way to convey our own personal narratives helps in the self-construction of lived experiences and ultimately reinforces health. Mental health professionals can prove a great resource in the process of assisting clients to find their own narratives. As discussed in the previous chapter, Ekins and King (2006) propose empowering "transcendent stories," where "self, body and gender redefining in the particular transcending story seeks to subvert and/or move beyond the binary divide" (p. 181). Selves, bodies, body parts, sexualities, and genders can take on new meanings within the redefined system of classification. Hird (2002), calls for "resisting constraining classifications, redefining classifications, and planning different strategies of resistance within different sites of power/knowledge" (Ekins and King 2006, p. 232). Burdge (2007), in fact, calls for social workers to empower transgender individuals to resist having to conform to the gender binary, but transgender theory, I think, provides a more comprehensive basis for this empowerment than queer theory.

Transgender theory suggests that the lived experiences of individuals, including their negotiations of multiple intersectional identities, may empower without confining us to any particular identity category. Transgender theory advocates for practitioners to look for sources of empowerment in the dynamic interactions among embodied and constructed aspects of identity. For example, Somerville (2000) discusses how intersectional identities can allow individuals to respond to the social forces that determine and objectify one's identities in multiple ways. In particular, she discusses Leslie Feinberg's (1993) semiautobiographical novel *Stone Butch Blues* about arriving at a "transgender" identity, voice, and subjectivity that transcends the socially defined gender category. It is the multiplicity of identities that allows Feinberg to achieve this, that "the emergence of this transgendered voice and subjectivity is mediated through racial discourses… through repeated invocations of Native American and African American culture and identity" (Somerville 2000, p. 171).

Lucal (1999) provides another example of a transcendent story based on embodiment. After discussing the various ways that her masculine physical appearance as an MTF caused those around her to have difficulty interacting with her, she nevertheless chose to "continue my nonparticipation in femininity" as "one of my contributions to the eventual dismantling of patriarchal gender constructs" (p. 793). Here the remnants of male embodiment were narrativized to not only be a source of personal meaning, but also as a basis for political activism. Mental health professionals can identify sources of empowerment in these intersectional identities of clients by encouraging clients to view a seemingly oppressed identity from the perspective of another identity. Eventually, this intersectional perspective may lead clients to understand their embodied ability to construct their own unique identity.

> **Transgender Interview:** As I transitioned to where I am now, I am much more understanding and caring than I used to be. I am not as aggressive, although I can be aggressive. You would not want to back me into a dark corner, because I would come out swinging, I would not give it a second thought, which is a much more male trait than it is female. But coming from that background, I also understand that sometimes you have to fight in life, and it may not be pretty, and it may not be the right thing to do, but sometimes it is the only thing you can do. So…I see myself at both ends of the scale, and a lot of points in between. I just see myself as a person, not as either male or female. Just as a person.
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> **Transgender Interview:** I see myself as predominantly feminine, but with a healthy dose of social masculine. …I will never deny the fact that for thirty years I lived as a man. I think that makes me stronger as a woman. I'm proud of that, I have lived and actually survived. So I define myself as embodying both, but more woman than man although, it is been a long time coming. It is getting ingrained culturally in sort of–behavior patterns, and the natural response—the default response—for the longest time is to respond in the old way, just act natural. At first you have to actively say, "Okay, now how would a woman think?" if you can imagine. But eventually it becomes ingrained, it becomes second nature, you shake off the dominant narrative, and you begin to express your own self, a sense of spirituality and connectedness. So, I would describe myself as having reached a point where I am more feminine than masculine.

Validation: Its Importance to Empowerment

Our language choices often communicate gender identity oppression and prejudice as it typically reinforces the gender binary. Language can be very validating or quite hurtful. Either by direct insult or by creating invisibility of lived experiences and self constructions of identity. This often goes unnoticed in our everyday interactions with individuals. When working with transgender individuals, Lindsey (2005) asks service providers to consider, "How to describe, in accessible language, such complicated and personal issues as one's gender identity or the choice to medically transition or how a searing homophobic or transphobic remark can damage our psyches? How to define words like 'transgender' or 'transsexual' or 'queer'–loaded words that some of us claim, others of us do not, and some do not even recognize or understand" (p. 185). The idea that we are just men and

women, and the effortlessness of this binary view, can lead to a reification of a simplistic binary view of gender (Looy and Bouma 2005). Mental health professionals should challenge categorical ways of thinking by integrating a more fluid view of gender for themselves. One way to do this is by addressing individuals by the name they prefer (Burdge 2007), avoiding automatically using words like "sir" or "madam," or any other gendered pronouns. It is important to simply ask an individual their preferred personal pronouns and the name they wish to be called. While this seems obvious, it is often not considered in everyday interactions.

We must note the constraints of contemporary social theories that still describe gender and sexual orientation in a categorical context, with social meanings of who is "masculine" and who is "feminine" and what those gendered bodies do and/or feel about one another. According to Valentine (2004), the concern is that gender-related categories are used as if they were valid and complete descriptions of the experience of gender, when such categories are not using all of the means for understanding that experience. We can avoid making assumptions about the motivations, behaviors, and attitudes of individuals based on gender identity categories and should be more sensitive to the conditional nature of these categories (McPhail 2004). For example, words like "real" or "biological," when applied to gender, can evoke strong emotional reactions (Mallon 2009).

Additionally, Halberstam (1998) notes that "many subjects, not only transsexual subjects, do not feel at home in their bodies," and that "there are a variety of gender variant bodies under the sign of non-normative masculinities and femininities, and the task at hand is not to decide which represents the place of most resistance but to begin the work of documenting their distinctive features" (p. 148). Mental health professionals can document these distinctive features, for example, by creating spaces on standardized forms for capturing variations in gender and by recording and disseminating the narratives of transgender individuals. This would both validate and create new gender categories that could help destabilize the existing binary system (Hausman 2001).

SB Journal Entry: (Sometime in 2010) In public, when I am alone, I am mostly referred to as sir, but when I am with other female bodied self-defined women, I am considered one of the girls…I find this strange and have contemplated why. I am guessing folks just cannot gender code me easily, so the default when I am alone is man, and when I am with others, woman. Still, people will often trip over their words with me. I get called sir until I start talking, and then it is quickly changed to ma'am since I do not have a very low voice. I do not care either way but the embarrassment folks demonstrate in the process often unnerves me and hurts me. I would like to say I do not care about not fitting in but it just is not always true. Sometimes, I just want to pass. I never pass. Bathrooms are a great example of my NOT passing. Bathrooms are always a challenge…women scream, run out of the bathroom, tell me I am in the wrong place and give me very dirty looks….it is tiring but what can I do? I cannot pass in a men's bathroom (too petite), and I am clearly not passing in the women's bathroom. I choose the women's since I feel there is less risk of violence for my transgression.

Transgender Interview: [Gender Identity]…It totally dictates in society because again it is how people interact with you. Unless they never see you and are always on the phone with you, but even then they are going to want to know whether to call you he or she. And once they have a label, they are going to interact on the phone with you

> differently. Probably the only time it does not matter is in that space of time before someone knows what you are, whether on the phone or writing to you. They cannot tell by your name, so they will indicate that in the letter and give it a neutral tone, kind of be really professional or whatever. But once they know, once they have a label, it totally dictates how they interact with you, even if they do not lay eyes on you.

The Power and Empowerment of Youth

With regard to the transgender community, there have been two assumptions made by most of society, and these are that gender identity and roles can be changed during early childhood and, secondly, that a person cannot be in psychological or psychosexual health unless their biological sex is unambiguous and/or "normal." Thus, one must need to have a harmony between their gender identity and their external body (Money 1986). These assumptions have been questioned but still continue to be held. Many who are currently diagnosed with gender identity disorder state that, from a very young age, they expressed a belief that they were of the other gender, and this is consistent with the experiences of our transgender participants quoted in the previous chapter. They reported that they played with members of the other gender and assumed the other gender role.

Morrow (2004) discusses social work practice with GLBT youth, identity development, family issues, and school issues. Morrow notes that, as adolescents transition through childhood toward adulthood, they experience a gender identity process where they no longer feel like they are children, but at the same time, they do not identify themselves as being adults yet. During this time, peer pressure is identified as being one of the primary stressors, especially for GLBT adolescents who are adjusting to socially unaccepted roles (Hetrick and Martin 1987). Many LGBT youth are verbally and physically harassed while on the school premises (Mufioz-Plaza, Quinn, and Rounds 2002). While the GLBT youth typically enter adolescence with little preparation for how to cope with their social identity, there are also few role models that they can look up to and depend on for guidance. These youth also find that it is difficult to talk with their families about their coming out process (Morrow 2004). Families and schools are often not prepared to have a GLB or a transgendered child, due to minimal accurate knowledge about their needs. Fearing that their families and peers will disapprove and reject them, many GLBT youth keep their sexual orientation or transgender identity to themselves creating further social and familiar isolation (Little 2001; Morrow 2004). Less so today but still prevalent, GLBT youths report the loss of friends following disclosures of their sexual/gender orientation (D'Augelli, Hershberger, and Pilkington 1998). The stresses of coping with their GLBT identity in a social environment that expects gender conformity put GLBT youth at higher risk for school problems and academic failure, family conflict, psychiatric disorders, including depression, substance abuse, and suicide (Hetrick and Martin 1987; Robinson 1994; Ramafedi 1987; Savin-Williams 1994). Mufioz-Plaza et al. (2002) found

that, compared to heterosexual youth, LGB youth were 2–6 times more likely to attempt suicide and made up more than 30 % of the total number of teen suicides. There is additional stress caused by youth not having control over medical decisions that affect their gender development, such as hormone therapies or gender reassignment surgery, while at the same time having to deal with the development of physical sex characteristics that they may be ashamed of (Burgess 1999). Quinn (2002) also reports on the high risk for alcohol and drug abuse, homelessness, prostitution, and suicide of GLBT teens, and that these teens often do not receive adequate services, due to the homophobic attitudes of child welfare department workers.

Quinn summarizes a survey conducted by Nocera (2000) of 254 state child welfare department workers on their beliefs, attitudes, and training needs with regard to the issue of sexual orientation and gender identity. The survey revealed that 33 % had beliefs that supported negative myths/stereotypes of GLBTQ people, while 41 % stated that they would not place a GLBTQ child in foster or adoptive care, based solely on the knowledge of whether or not the foster parents were also GLBTQ identified. Ironically, 83 % of the workers surveyed were aware of actually having GLBTQ clients within their caseload, 45 % also reported that they were not aware of available community resources for GLBTQ clients, or they left the question blank entirely (Nocera 2000). Nocera's study suggests that the homophobic attitudes and lack of information about GLBTQ resources of child welfare workers causes these workers to be lacking in their responsibilities to protect all children in state care. Such attitudes must be identified, challenged, and changed (Quinn 2002). As is apparent from the above studies cited, little research has focused specifically on transgender, as opposed to gay and lesbian youth. Raiz and Saltzburg (2007) and Saltzburg (2008) have proposed and implemented narrative techniques in the professional training of social work students to reduce negative attitudes and behaviors in working with gay and lesbian clients.

We have a great opportunity and obligation to assist our youth through the often difficult process of embracing their embodied self in order to create their own self construction of who they are and wish to become. Teaching them how to deal with the fluidness of identity in a non-fluid world is a great challenge. The power of youth is that their minds are often freer than ours to think bigger thoughts and break through bigger barriers on limiting social constructs that seem so intractable in adulthood. Their empowerment is our responsibility. We must nurture and protect our youth so they may find their own path to selfhood without the risk of harm. The rash of recent suicides and the spotlight on bullying of queer youth highlight the great need for our efforts.

SB Journal Entry: (March 2012) While doing some web research, I came across a Yahoo poll with the following question: Can Children be Raised in a Gender Free Environment? Now, I do not usually play these polls but every now and then I jump. I could not pass this up with 76,051 respondents to the question. I expected the answer to be lopsided, not in my favor, of course, but I figured a 60/40 split. The response was 14 % yes, 86 % no, which really gets to the issue of and need for more activism to create the cultural shift necessary for gender neutrality to be embraced. If we do not get cultural shift, we would not be able to sustain even the limited public policy gains we have made. We are still

losing on this front. There was nothing very scientific about this poll but I suspect it is closer to the reality on the ground than any of us care to admit.

SB Journal Entry: (May 2012) In a recent conversation with a friend, she told me of her child, who is under ten and gender non-conformist. This is fine with her but she and her young child must negotiate an ex-husband who believes in gender conformity, a school system with constraints on gender appropriate clothing, and her child's wishes to begin modifying the physical body to reflect preferences for a non-conformist gender presentation. The child is perfectly fine. Society is not. This child's liberation from normative gender conformity requires our support and admiration. We must provide the space to protect this child from the harmful consequences of normative gender constructs.

SB Journal Entry: (sometime in the spring of 2012) I have been deeply involved in the lives of my friends' children, and after years of participating in their development, the oldest son, now 18, has given me a new designation…the mom/dad. The middle son, now 14, was also a part of this distinction. The children have observed that, when Dad is solo parenting and I am present, I take on the Mom qualities…when Mom is solo parenting, and I am present, I take on the Dad qualities. This observation is an accurate analysis of my trans-identity. I am both and more. I am a man, woman, neither, both,…physically, emotionally and spiritually.

Transgender Interview: Just talking to my mom, it seemed it was about three or four when she noticed gender non-conforming behavior in dress. Then I remember, when I was in fourth grade, always wanting to wear dress pants and more masculine shirts, and I never wanted to wear jeans, and I wanted to look very, very good. Which I look at now, and, like, oh my God, I was such a gay guy. And I also really liked to wear ties, and my mom let me wear them to school. And I, it just felt normal to me to do that, but then I got teased for it, and I stopped doing it…..Basically, from growing up, I expected to be a certain way, being born female, being socialized as a girl, expected to wear dresses and to not get dirty and all that. I preferred to wear boys' clothes and hang out with the boys, and I still did not want to get dirty. There is that aspect growing up, and wanting to still not feel so different, so I really tried to fit in and I tried to dress and act in the ways that were expected of me.

SB Journal Entry: (March 2012) I spent some time with homeless youth recently. Most were queer (my definition) and being served by a queer organization, although their mission was universal service to homeless youth. To begin the meeting, the youth wished to go around the room, where we introduced ourselves and gave our preferred personal pronoun (PPP). I told the group I defined as queer, and they could call me by any pronoun they preferred. The youth clearly wanted more from me than queer…so I went on to tell them I identify as trans, and they could call me anything they wanted, as long as it was nice. This event reminded me of how labels and terms remain as fluid as identities and how important peer defined labels for our identities can create empowerment or disempowerment. I identify as queer. They needed to know I identify as trans. On a personal level, I consider my trans-identity a much more intimate identity that I share only when I want to, and my queer identity is for complete public consumption. For me, it is more personal because it is the essence of how I know myself. Every incident and event in my life is filtered through my queerness and felt through my transness.

Final Thoughts

The goal of this chapter was to present the application of trans-identity theory to practice with transgender individuals, with the ultimate hope of helping those who identify as trans to arrive at a place of empowerment and health. For me, personal empowerment evolves, is arrived at, achieved, lost and found again and again. It is

helpful for me to have a comprehensive theory of trans-identity that I can use as a lens to analyze myself. It helps me to consider and reconsider the fluidness of my gender identity and what that means to me. It seems I am always in flux, creating, and recreating myself over my lifetime. Today, I am in a particularly good place.

> **SB Journal Entry:** (Saturday, June 2011) Chicago Dyke March, each year the dyke march committee picks a different location in the city to March for queer awareness… Pride weekend. At the end of the March, we all gathered in a park on the Southside of Chicago to eat, listen to speakers, hear music, and do some general people watching. Friends embraced, and the general sense of goodwill was palatable. Dykes, gay folks, couples, children, drag kings and queens, tattooed, pierced, leathered, cross dressers, queers, allies, trannies, and many more identities in the gender variant crowd getting along. I thought to myself, "how far have we come?" Susan Stryker (2008), in her transgender history book, speaks of the "difficult years," when the trans community was ostracized from the feminist/lesbian communities. The transphobia was deep and hurtful. Have we finally overcome it? A woman at one point sits with me on a blanket…a friend of some friends, a lovely, young spirited transsexual. Two allies joined us, what I would consider good feminist men and two of their friends. I was there with two dykes and, of course, one transgender me (who thinks of herself most often as him but forgets that people get confused and do not always see it that way). A speaker representing the dyke March committee got up to read a statement on behalf of the committee apologizing for a transphobic incident directed toward a transgender woman that occurred at the March a couple of years ago. Oh, yes, now we have arrived, affirmed with a public apology. It was a validating and deeply moving moment for me.